STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

INFORMATIONAL LETTER NO. 697

To: All Iowa Medicaid Physician, Dentist, Podiatrist, Pharmacy, Home Health Agency, Rural Health Clinic, Clinic, Skilled Nursing Facility, Intermediate Care Facility, Community MH, Family Planning, Residential Care Facility, ICF MR State, Community Based ICF/MR Providers
From: Iowa Department of Human Services, Iowa Medicaid Enterprise
Date: March 31, 2008
Subject: Iowa Medicaid Pharmacy Program Changes
Effective Date: **April 30, 2008**

1. Changes to the Preferred Drug List (PDL)[1]

Preferred	Non-Preferred		Recommended
Amoxicillin/Clavulanate 200/5 Susp	Acthar® HP	Oxcarbazepine	Isentress™
Betaseron®	Aldactazide® 25/25	Pantoprazole[4]	
Brimonidine 0.2% Opth Soln.	Augmentin® 200/5 Susp[2]	Penicillin G 250mg (Brand)	
Cabergoline	Azor™	Phenergan® 12.5mg Supp.	
Cefprozil 250mg Susp.	Balsalazide	Ramipril	
Ceftriaxone	Bystolic™	Rocephin®[2]	
Chantix™ [4]	CaloMist™	Toprol XL®[2]	
Clindamycin 1% Lotion[4]	Cefzil® 250mg Susp.[2]	Tyzeka™	
Glucagen®	Ciclopirox	Ultravate™ 0.05% Cream[2]	
Halobetasol 0.05% Cream	Clecoin-T® 1% Lot[2] & Sol	URSO®	
Hepsera®	Combigan™		
Metronidazole 0.75% Cream[4]	Desowen® Ointment		
Metoprolol ER	Diprolene®		
Norgestrel & Ethinyl Estradiol 0.3mg/30mcg	Erygel®		
Propranolol CR	Extina® Foam		
Pulmicort® 1mg Respules[3]	Famciclovir		
Quinapril	Flector® Patch[4]		
Sanctura XR™	Garamycin® Opthalmic		
Terbinafine[4]	Glipizide/Metformin		
Terconazole 0.4% Vaginal Cream	Glucagon Emergency Kit[5]		
Tizanidine 2mg	Granisetron		
Zemplar® Capsules	Haldol® Lactate Concentrate		
Zemplar® Injection	Inderal® LA		
	Ipratropium/Albuterol Soln.		
	Kayexalate®		
	Lamisil®[2]		
	LO/Ovral®[2]		
	Metrocream®[2]		
	Moexipril/HCTZ		

[1] Dostinex®, Ethmozine®, Exubera®, and Haldol® have been removed from the PDL due to discontinuation by the respective manufacturers.
[2] After 30 days, only the generic will be preferred
[3] Preferred for children < 8 y/o
[4] Clinical PA Criteria Apply
[5] Will remain preferred for 90 days before switching to non-preferred

2. Changes to the Maximum Quantity Prescribed and Dispensed

- Effective **April 1, 2008**, when it is not therapeutically contraindicated, a legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a maximum of a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.
- Pharmacies should take steps to ensure the quantities of medications dispensed are in multiples of the prescriptions' days supply. The Iowa Medicaid Enterprise will be monitoring adjudicated claims to ensure the quantities dispensed are consistent with the reported days supply.

3. Drug Prior Authorization

a. Changes to Existing Prior Authorization Criteria

- **Amylino Mimetic (Symlin®):** Will now require documentation of blood glucose monitoring at least three times per day. Documentation of an inadequate reduction in HbgA1C despite multiple titration with basal/bolus insulin dosing regiments must also be provided. Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period.
- **Incretin Mimetic (Byetta®):** Will now require an unsuccessful trial with a combination of two or more antidiabetic medications (metformin, sulfonylurea, or thiazolidinedione) at maximum tolerated doses. Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period.
- **Non-Parenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products:** Only DDAVP® ***tablets*** will be approved for the diagnosis of nocturnal enuresis.
- **Palivizumab (Synagis®):** Will now include criteria for use in patients with congenital heart disease and severe immunodeficiency, in addition to prematurity.
- **Sedative/Hypnotic Non-Benzodiazepines:** Will now allow a quantity of ***15 units per 30 days without a prior authorization***. If more than 15 units of a preferred drug are required per 30 days, the following must be provided: 1) A diagnosis of chronic insomnia (insomnia lasting ≥ 6 months) following at least a two consecutive month trial of an approved quantity (15/30) of the requested drug, 2) Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued, 3) Enforcement of good sleep hygiene is documented, 4) All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses.

b. **New Prior Authorization Criteria** – See prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.

- **Biologicals used for Ankylosing Spondylitis:** Adalimumab (Humira®), Etanercept (Enbrel®), Infliximab (Remicade®). Prior authorization is required for biologicals used for ankylosing spondylitis. Payment will be considered following an inadequate response to a preferred NSAID. Prior authorization is required for all non-preferred biologicals for ankylosing spondylitis as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred biologicals for ankylosing spondylitis will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.
- **Biologicals used for Arthritis:** Abatacept (Orencia®), Adalimumab (Humira®), Anakinra (Kineret®), Etanercept (Enbrel®), Infliximab (Remicade®). Prior authorization is required for biologicals used for arthritis. Payment will be considered following an inadequate response to a preferred disease modifying antirheumatic drug such as hydroxycholoroquine, sulfasalazine,

methotrexate, leflunomide, d-penicillamine, azathioprine, oral gold, or intra-muscular gold. Prior authorization is required for all non-preferred biologicals for arthritis as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

- **Biologicals for Inflammatory Bowel Disease:** Adalimumab (Humira®), Infliximab (Remicade®). Prior authorization is required for biologicals used for inflammatory bowel disease. Prior authorization is required for all non-preferred biologicals for inflammatory bowel disease as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.
  - Crohn's Disease: Payment will be considered following an inadequate response to a preferred conventional therapy such as aminosalicylates (mesalamine, sulfasalazine), corticosteroids, azathioprine/6-mercaptopurine, and/or methotrexate
  - Ulcerative colitis (moderate to severe): Payment will be considered following an inadequate response to a preferred conventional therapy such as aminosalicylates, corticosteroids, and/or azathioprine/6mercaptopurine.

- **Biologicals for Plaque Psoriasis:** Alefacept (Amevive®), Adalimumab (Humira®), Efalizumab (Raptiva®), Etanercept (Enbrel®), Infliximab (Remicade®). Prior authorization is required for biologicals used for plaque psoriasis. Payment will be considered following an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine. Prior authorization is required for all non-preferred biologicals for plaque psoriasis as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

c. Glucagon Rescue Kits

The IME will allow a 90 day transition period where both "Glucagon Emergency Kit" by Eli Lilly and Company and "GlucaGen Hypo Kit" by Novo Nordisk will be preferred drugs on the PDL. Following this transition period, Glucagon Emergency Kits will be a non-preferred drug on the PDL and GlucaGen Hypo Kit will be the only preferred agent.

4. Proper Crediting Iowa Medicaid for Return Of Drugs

Iowa Medicaid Long Term Care Pharmacy Providers and Nursing Home Facilities who serve Iowa Medicaid Members are to be reminded that proper credit to Iowa Medicaid is required for the return of unused medications upon therapy discontinuation, member discharge, transfer, or death in accordance with State law. The Iowa Medicaid Prescribed Drugs Provider Manual states, "Any previous charges for intact unit-dose packages returned to the pharmacy must be credited to the Medicaid program. Such credits may be shown on future billings. If no additional billings are to be made, direct a refund in the drug cost component." Please refer to Informational Letter 497 for additional information.